Table 2 Reasons for stopping topical g.CsA 1 mg/ml

Person deciding to discontinue treatment	Reason for discontinuation	*n*	%
Family/child	Resolution of symptoms	6	12
	Stinging on instillation, eyes felt worse	2	4
	Reason not documented	9	18
Ophthalmologist	Resolution of symptoms/ Improvement of signs	5	10
	Patient intolerance	1	2
	No improvement in response to treatment	3	6

neoplasia, although the previous data for other preparations used for over 30 years indicate that the risk of serious adverse events is minimal and unproven [4].

Based on this study, our first cases and continuing experience in using the new preparation, topical CsA appears safe and highly effective for disease control and as a steroid-sparing agent in chronic ocular surface inflammation in children at a dose of between two and four times daily. The lack of licence for this age group and indication leads to difficulties accessing it from non-specialist units and as repeat prescriptions in primary care. A randomized controlled trial of g.CsA 1 mg/ml in children with VKC has recently been completed [5], and licensing for this indication and age group will permit wider use.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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Comment on: 'An international comparison of retinopathy of prematurity grading performance within the Benefits of Oxygen Saturation Targeting II trials'

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Fleck et al. have noted international differences in inter-observer variation in ROP grading and management between UK and Australian/New Zealand (ANZ) ophthalmologists [1, 2].

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Eight consultant ophthalmologist ROP screeners in Scotland graded RetCam (Natus Medical, Pleasanton, CA, USA) images of 25 eyes of 25 infants regarding the presence and severity of plus disease, and stated their management decision ('treatment' or 'no treatment'). Clinical information on gestational age at birth, birth weight, and post-gestational age at the time of imaging was provided. Graders viewed the revised standard ICROP photograph for plus disease prior to commencing the task [3]. Thirteen of the 25 eyes were treated for ROP.

Inter-observer agreement (Fleiss-Kappa, where 0.21–0.40 is considered 'fair') was 0.34 (95% CI = 0.28–0.39) for the presence of plus and 0.40 (95% CI = 0.33–0.48) for management decision, slightly greater than that reported by Fleck et al. for UK ophthalmologists (0.2 and 0.33, respectively) [2].

Our data supports the poorer degree of inter-observer agreement found for UK ophthalmologists compared with those of the ANZ group, who had lower treatment rates, although comparable visual outcomes, in the BOOST II trials [4]. The ANZ grading group self-certified using a training website. Given that a possible tendency towards over-treating ROP could result in unnecessary morbidity, the development of a similar online tool to improve standardisation and management decisions would be of potential benefit to UK ophthalmologists.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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